

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

00393

1. PLACE OF DEATH:

County Cecil
 City or town North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Cecil
 City or town North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Pearl Elaine San Boeuf

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 21 1942

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

479

hrs.

min.

9. Birthplace

Larne De Grace Md.
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

MOTHER FATHER

12. Name

Robert San Boeuf

13. Birthplace

New Rochelle N.Y.

14. Maiden name

Pearl Harter

15. Birthplace

Dover Del.

16. Informant

Robert San Boeuf

Address

Charles North East Rd Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Jan. 12, 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Jan. 10 1948

(Date rec'd by registrar)

19.

James E. Dougherty

(Registral)

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 8 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Charred Body

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1-9-48Where did injury occur North East Rural Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury House burned Injured at work?

23. SIGNATURE

R. E. Dodson
Address Perryville, Md. Date signed 1-9-48

Medical Examiner

for Cecil County

M. D. or other



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00394

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs. 10 mos. 10 days
 Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
Unknown
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County _____
 City or town Alexandria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 221 North 221 Southwest Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war VW-I

3. (a) FULL NAME

BROWN, George A.

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 12, 1896
 8. AGE: Years 51 Months 1 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name Edward F. Brown
 13. Birthplace Unknown
 14. Maiden name Fannie (?) Brown - deceased
 15. Birthplace Unknown

16. Informant Hospital records
 Address VAH, Perry Point, Md.
 17. Removal Date thereof Jan. 6, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Name unknown
 Location Alexandria, Va.
 18. Funeral directed by Pennington & Son
 Address Havre de Grace, Md.
 19. Jan 6, 1948 Irma E. Dougherty
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1948 at 1:16 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death General Paralysis of the Insane Over 10 yrs.
 DURATION

Due to _____

Due to _____

Other conditions _____

Nephrosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE V. COVALESKY, M.D., Actg. Chf. Dir.

Address VAH, Perry Point, Md. Date signed 1-6-48

RECEIVED
JAN 7 1948
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil

City or town... Elberton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Elberton R. D. 5
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Ida Simpser Bullock

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George M. Bullock

7. Birth date of

deceased (mo., day, yr.)

June 12 1898

6. (c) If alive, give age... years

8. AGE:

Years 49

Months 6

Days 25

If less than one day

hrs. min.

9. Birthplace

Covington Cecil Co. Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Cov Simpson

13. Birthplace

Md

MOTHER

14. Maiden name

Williamina Lloyd

15. Birthplace

Md

16. Informant

George M. Bullock

Address

Elberton, R. D. 5 Md

17. Burial
(Burial, cremation, or removal. Which?)Date thereof Jan 9 1948
(month) (day) (year)

Cemetery or crematory

Union

Location

Elberton Rural

18. Funeral director

Joseph R. Grant

Address

North East Md

19. Jan 7 1948
(Date rec'd by registrar)

JH Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 23 1947 to Jan. 6 1948

and that I last saw her alive on Jan 6 1948

Immediate cause of death

Intestinal obstruction

DURATION

Due to

Intestinal adhesions

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

abdominal adhesions

Autopsy results

None organized general

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

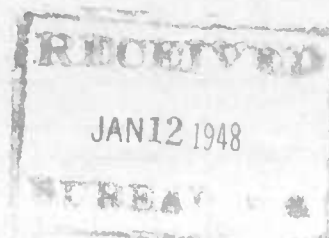
Injured at work?

23. SIGNATURE

Mildred H. Sprecher

M. D. or other

Address... Elberton, Md Date signed... Jan 6 '48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....**CECIL**
 City or town.....**PERRY POINT, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**4 yrs. 8 mos. 29 das.**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution?.....**5 yrs.**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....
 City or town.....**Washington, D.C.**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**410-11th St., S.E.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....**WW-I**

3. (a) FULL NAME

WILLIAM J. COOGAN

3. (b) Social Security Number

4. Sex.....**Male**
 5. Color or race.....**White**
 6. (a) Single, married, widowed, or divorced.....**Divorced**
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....**September 26, 1878**
 8. AGE: Years.....**69** Months.....**4** Days.....**4** If less than one day..... hrs. min.

9. Birthplace.....**Michigan**
 (Town, county, and state)
 10. Usual occupation.....**Painter**
 11. Industry or business.....

12. Name.....**Deceased**
 13. Birthplace.....
 14. Maiden name.....**Deceased**
 15. Birthplace.....

16. Informant.....**Hospital Records**
 Address.....**VAH, Perry Point, Maryland**
 17. Removal.....**Removal** Date thereof.....**2-3-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....**Baltimore National Cemetery**
 Location.....**Baltimore, Maryland**
 18. Funeral director.....**Funeral Home**
 Address.....**Havre de Grace, Maryland**

19. **Feb. 3, 1948** **James E. Dougherty**
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**January 30th** 19 **48**, at **5:35P.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1st 19 **43**, to **Jan. 30th** 19 **48**
 and that I last saw him alive on **January 30th** 19 **48**

Immediate cause of death.....**Cerebrovascular Accident**
 DURATION.....**2 days**

Due to.....**Arteriosclerosis**
 Unknown

Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....**None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....**A.E. TROLLINGER, M.D., Chief, Prof. Ser.**
VAH, Perry Point, Md. M. D. **2/3/48**
 Address..... Date signed.....

RECEIVED

FEB 6 1948

SUBSIST

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

00397

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County BecilCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hosp.
How long in hospital or institution? 10 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BecilCity or town Elkton - ms.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Thomas R. Davis

3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white widower6.(b) Name of husband or wife Martha Davis7. Birth date of deceased (mo., day, yr.) August 18, 1860
8. AGE: 87 years 4 months 29 days 1 less than one day9. Birthplace Becil County - Md
(Town, county, and state)10. Usual occupation Retired Storekeeper11. Industry or business General store12. Name John Davis13. Birthplace Becil Co - Md14. Maiden name Estherine Lake15. Birthplace Becil Co - Md16. Informant Mrs Robert BoydAddress North East - Md17. Burial Date thereof Jan 18 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Cemetery (Friends)Location Cecil, Md18. Funeral director Joseph R. GrantAddress North East, Md -19. Jan 17 19 48 J.F. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1948 at 4:00 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14, 1947 to Jan 16, 1948
and that I last saw him alive on Jan 16, 1948Immediate cause of death Acute cardiac decompensation
knownDue to General arterio sclerosis
known

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

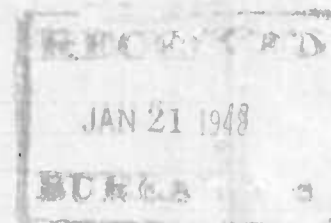
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. McHugh M.D.Address Elkton - Md M. D. or other _____Date signed Jan 16 - 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *92*

00398

1. PLACE OF DEATH:

County *Sevier*
City or town *Ellettsville*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Union Hospital Ellettsville

How long in hospital or institution?

6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ind.* County *Sevier*
City or town *North East*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

S Annie Dean

3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

John H Dean

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 15 1872

8. AGE:

Years

Months

Days

If less than one day

75

4

11

hrs.

min.

9. Birthplace

Polandville, Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

George Hodge

13. Birthplace

Germany

14. Maiden name

Mary Laurie

15. Birthplace

Scotland

16. Informant

Mrs. Atlee Armour-daughter

Address

North East, Ind.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 28-48
(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East, Ind.

18. Funeral director

Joseph P. Jones

Address

North East, Ind.

19.

(Date rec'd by registrar)

Jan 27 1948

J R Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 26

19

48

at

440 E. M

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

1-20

19

48

to

1-26

19

48

and that I last saw him alive on

1-25

19

48

Immediate cause of death

Lobar Pneumonia
Right side.

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Bill Dodson MD

23. SIGNATURE

William G. Dunsford

M. D. or other

Address

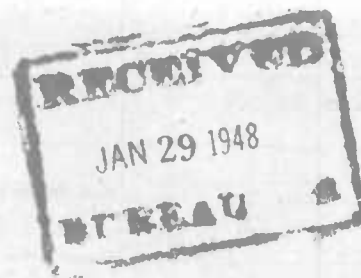
Date signed

1-27-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: *Cecie*
 County *Elkton*
 City or town *Elkton*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Residence - St. Main St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Cecil*
 City or town *Elkton*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *W. Main St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Louis Rudolph Ehlers*

3. (b) Social Security Number
222-09-1292A

4. Sex *male* 5. Color of race *White* 6. (a) Single, married, widowed, or divorced *married*
 6. (b) Name of husband or wife *Mabel Sophia Ehlers*
 7. Birth date of deceased (mo., day, yr.) *Aug 8 - 1869*
 8. AGE: Years *78* Months *6* Days *7* If less than one day .hrs. .min.

9. Birthplace *Easton - Pa*
 (Town, county, and state)

10. Usual occupation *Refrigeration*

11. Industry or business *construction & rebuilding*

12. Name *Christiana Ehlers*

13. Birthplace *Germany*

14. Maiden name *Winkorowich*

15. Birthplace *Ireland*

16. Informant *Wife: Mabel Sophia Ehlers*

Address *W. High St Elkton*

17. *Burial* Date thereof *Jan 21, 1948*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Elkton*

Location *Elkton, Md.*

18. Funeral director *D. W. Pippin & son*

Address *Elkton, Md.*

19. *Jan 20* 19 *48* *FR Trauger*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 18th* 19 *48*, at *8:30 P. M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 23 - 1947* to *Jan 18 - 1948*

and that I last saw him alive on *Jan 18th* 19 *48*

Immediate cause of death *Carcinoma of lung about 2 yrs*

Due to

Due to

Other condition *Had prostate removed 3 yrs ago which showed carcinoma -*

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *T. H. McLaughlin M.D.*

Address *Elkton - Md.* Date signed *1-19-48*

RECEIVED

JAN 23 1948

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00400

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Perry Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs. 8 mos. 12 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
City or town Crisfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war Spanish American

3. (a) FULL NAME

ELLET, Milley W.

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 26, 1879
8. AGE: Years 68 Months 9 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Crisfield, Maryland
(Town, county, and state)
10. Usual occupation None
11. Industry or business _____
12. Name Unknown - deceased
13. Birthplace Unknown
14. Maiden name Mary Horner - deceased
15. Birthplace Unknown

16. Informant Hospital Records
Address VA Hospital, Perry Point, Md.
17. Removal Date thereof Jan. 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Unknown

Location Crisfield, Maryland
18. Funeral director PENNINGTON & SON
Address Havre de Grace, Md.
19. Jan. 10 19 48 James E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 19 48, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 19 39, to Jan. 9, 19 48, and that I last saw him alive on January 9, 19 48.

Immediate cause of death Bronchopneumonia DURATION 2 weeks

Due to Senility

Due to _____

Other conditions _____

Dementia Praecox, Hebephrenic type
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. E. TROLLINGER
A. E. TROLLINGER, M.D., Clinical Director
Address VAH, Perry Point, Md. Date signed 1-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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RECEIVED
JAN 13 1949
BTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of date of death shown on:

FORM No. G 115 MAY 3 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....**CECIL**
 City or town.....**PERRY POINT, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**2 mos. 16 das.**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution?.....**Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....**MARYLAND** County.....**Baltimore**
 City or town.....**Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**2018 Hollins Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....**WW-I**

3. (a) FULL NAME

JOSEPH S. FALICE

3. (b) Social Security Number

4. Sex.....**Male** 5. Color or race.....**White** 6.(a) Single, married, widowed, or divorced.....**Married**
 6.(b) Name of husband or wife.....**Beulah Conrad**
 6.(c) If alive, give age.....**41** years
 7. Birth date of deceased (mo., day, yr.).....**July 10, 1891**
 8. AGE: Years.....**56** Months.....**5** Days.....**4** If less than one day.....hrs.min.

9. Birthplace.....**Naples, Italy**
 (Town, county, and state)
 10. Usual occupation.....**Auto Mechanic**
 11. Industry or business.....
 12. Name.....**Deceased**
 13. Birthplace.....
 14. Maiden name.....**Deceased**
 15. Birthplace.....

16. Informant.....**Hospital Records**
 Address.....**VAH, Perry Point, Md.**
 17. Removal.....**1/15/48**
 (Burial, cremation, or removal. Which?) Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....**Baltimore National Cemetery**
 Location.....**Baltimore, Maryland**
 18. Funeral director.....**James E. Daugherty**
 Address.....**Havre de Grace, Maryland**
 19. Jan. 15 19 48 James E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**January 14th 13th 19 48** at.....**4:50P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 18th 19 47 to **Jan. 14th 19 48**
 and that I last saw him alive on **January 14th 19 48**

Immediate cause of death.....**Coronary Arteriosclerosis**
 DURATION.....**Unkwn.**

Due to.....**Arteriosclerosis, general**
 DURATION.....**Unkwn.**

Due to.....
 DURATION.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....**Confirms above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....**A. E. TROLLINGER, MD., Clin. Director**
VAH, Perry Point, Md.Address..... Date signed.....**1/15/48**

RECEIVED

JAN 19 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL
City or town PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos. 12 das.
Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Frederick
City or town Emmitsburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. SAW
(If rural, give LOCATION)
2. (a) If veteran, name war SAW

3. (a) FULL NAME

JOSEPH GAMBLE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife ---
7. Birth date of deceased (mo., day, yr.) June 17, 1865
8. AGE: Years 81 Months 6 Days 25 If less than one day --- hrs. --- min.

9. Birthplace St. Joseph, Mo.
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business ---

12. Name Samuel Gamble
13. Birthplace Emmitsburg, Maryland
14. Maiden name Emma R. Danner
15. Birthplace Emmitsburg, Maryland

16. Informant Hospital Records
Address VAH, Perry Point, Md.
17. Removal Date thereof 1/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unknown
Location Rocky Ridge, Maryland
18. Funeral director James E. Langford
Address Havre de Grace, Maryland
19. Jan. 13 19 48 James E. Langford
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 48 at 1:35 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30th 19 46 to Jan. 12th 19 48
and that I last saw him alive on January 12th 19 48
Immediate cause of death ---

Due to Bronchopneumonia 1 week
Bronchiectasis over 20yrs
Due to ---
Other conditions Fibrous pulmonary T.B.,
Fibrous pleurisy; Hypertrophied prostate
(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
Autopsy results Confirms above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---
23. SIGNATURE A. E. Trollinger
A. E. TROLLINGER, M.D., clin. director
Address VAH, Perry Point, Md. Date signed 1-12-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 15 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00403

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Port Deposit, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Cecil
 City or town..... Port Deposit, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Allen M. Green

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... Laura Green
 7. Birth date of deceased (mo., day, yr.)..... ? 1867
 8. AGE: Years..... 80 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Port Deposit, Cecil Co., Md.
 (Town, county, and state)
 10. Usual occupation..... Laborer Farm
 11. Industry or business.....

FATHER 12. Name..... James Green
 13. Birthplace..... Cecil Co., Md.
 MOTHER 14. Maiden name..... Julia Taylor
 15. Birthplace..... Cecil Co., Md.

18. Informant..... Nelson Green
 Address..... 1837 Christian St., Phila. Pa.
 17. Burial..... Date thereof..... Jan. 10, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Coakesbury

Location..... Port Deposit, Md. Rural
 18. Funeral director..... Lee A. Patterson & Son
 Address..... Perryville, Md.

19. Jan. 10 1947 Dr. E. Langhorne
 Date rec'd by registrar..... Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 1-8 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5:45 to 5:50 1948 and that I last saw him alive on Dec 24 1947

Immediate cause of death..... Myocardial infarction
 well past infarction

Due to..... 1948

Due to.....

Other conditions..... Prostateitis

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

13. SIGNATURE..... M. D. or other
 Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00404

92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton R.D. 5
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Ind. County Cecil
 City or town Elkton R.D. 5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clifford Daniel Hall

3.(b) Social Security Number

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1948, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death
Bullet wound
in head.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 1-26-48Where did injury occur? Elkton Rural and Ind.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Revolver - 38 Injured at work?

23. SIGNATURE

R. L. Dockrill Medical Examiner
Elkton County
 M. D. or other
Reagan Smith Date signed 1-27-48

MOTHER FATHER

12. Name J. Wilmer Hall
 13. Birthplace Elkton Ind.
 14. Maiden name Mary Eliza Sneed
 15. Birthplace Cheney Co Pa.

16. Informant Samuel J. Hall
 Address Elkton R.D. 5 Ind.

17. Burial Date thereof Jan 30 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oxford Pa
 Location Oxford Pa

18. Funeral director W. J. Jones
 Address Baltimore Md

19. Jan 29 1948 FR Frazier
 (Date rec'd by registrar) Registrar

RECORDED
JAN 31 1948
STREAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0040596

1. PLACE OF DEATH:

County Cecil
 City or town Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Cecil
 City or town Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Susquehanna St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sterling Craig Hasson

3. (b) Social Security Number

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Eleanor Link Hasson7. Birth date of deceased (mo., day, yr.) Nov. 19, 1904 6. (c) If alive, give age 40 years8. AGE: Years 43 Months 1 Days 23 If less than one day hrs. min.9. Birthplace Chester Md. (Town, county, and state)10. Usual occupation Passenger Conductor11. Industry or business P. R. R.12. Name Alexander Hasson13. Birthplace Port Deposit Md.14. Maiden name Grace Craig15. Birthplace Cragtown Md.16. Informant Irene Willard Hasson17. Burial Date thereof Jan. 14, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Asbury Cemetery
 Location Port Deposit, Md. Rural18. Funeral director Lea Patterson & SonAddress Perryville, Md.19. Jan 12 1948 Irene E. Dougherty Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1948 at 29 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19Immediate cause of death Myocardial Infarction of heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicideWhere did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?23. SIGNATURE R. E. Dodson Medical Examiner
 Address Perryville, Md. Date signed 1-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

00406

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

County Essex
 City or town Essex
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 hours
 Hospital, institution, or street address where death occurred
Union Hosp. Essex Md
 How long in hospital or institution? 48 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Delaware County Worcester
 City or town New Castle Co. New Castle
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Ollie Hines

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced no information

6. (b) Name of husband or wife no information

7. Birth date of deceased (mo., day, yr.) no information 1905
 6. (c) If alive, give age _____ years

8. AGE: Years 43 Months no inf Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace no information
 (Town, county, and state)

10. Usual occupation no inf.

11. Industry or business

12. Name no inf.13. Birthplace " "14. Maiden name " "15. Birthplace " "16. Informant Informant MedicalAddress Reynolds Ave Md

17. Burial Date thereof Feb 11/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory County Burial groundLocation Childs Md18. Funeral director H. WhitingAddress Essex Md19. Feb 11 19 48 JR Frazer

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 19 48 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Fractured Skull
1 ft femur

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

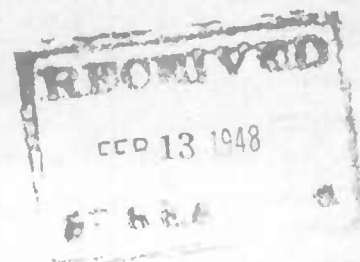
Accident, suicide, or homicide Elderly death Date of Jan 15-48

Where did injury occur? Essex Rural Care (City or town) Essex (County) Essex (State) MD

Injured at home, farm, industry, public place (where?) Route 40

Means of injury Struck by truck Injured at work? no

23. SIGNATURE Reynolds Ave Md Medical ExaminerAddress Reynolds Ave Md Date signed 1-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00407

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... One Month
 Hospital, institution, or street address where death occurred:
 3 Susquehanna Ave.,
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Delaware County..... Sussex
 City or town..... Bridgeville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Rev. John C. B. Hopkins

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Grace F. Hopkins

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... February 4, 1881

8. AGE: Years..... 66 Months..... 11 Days..... 21
 If less than one day..... hrs. min.

9. Birthplace..... Bethel, Sussex Co., Delaware
(Town, county, and state)

10. Usual occupation..... Clergyman

11. Industry or business..... M.E. Church

12. Name..... Calvin Hopkins

13. Birthplace..... Delaware

14. Maiden name..... Anna Mary Spicer

15. Birthplace..... Delaware

16. Informant..... Rev. Ralph W. Hopkins

Address..... Perryville, Md.

17. Burial.....
 (Burial, cremation, or removal. Which?).....
 Date thereof..... January 28, 1948
 (month) (day) (year)
 Cemetery or crematory..... Denton

Location..... Denton, Caroline Co., Md.

18. Funeral director..... W. A. Patterson & Son

Address..... Perryville, Md.

19. Jan 27 1948.....
(Date rec'd by registrar)

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 25 Jan 1948 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on 25 Jan 1948

and that I last saw him alive on 25 Jan 1948

Immediate cause of death.....

Coronary Thrombosis

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. H. Sadowsky M.D.

Address..... Perryville, Md.

Date signed..... 27 Jan 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a

00408

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Elkton
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Union Hosp.
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Elkton
 City or town Elkton (Elkton - RD) MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Helen O. Hutchins

3. (b) Social Security Number

4. Sex Female 5. Color or race black 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife Alex Hutchins
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) unknown July 31 - 1873
 8. AGE: Years 74 Months 5 Days 12 less than one day _____ hrs. _____ min.
 9. Birthplace Denton - Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Helen Gibson
 15. Birthplace Unknown
 16. Informant Esther Williams - daughter
 Address Elkton - MD
 17. Burial Date thereof 1/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Elkton
 Location Elkton MD
 18. Funeral director R. B. Rawlings
 Address Greensboro Md.
 19. Jan 12 1948 AB Frazier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1948 at 8:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 - 1948 to Jan 12 1948 and that I last saw him alive on Jan 12 1948
 Immediate cause of death Cerebral Paralysis DURATION 8 days
 Due to General Cardio-renal Vascular disease unknown
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operation _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE R. B. Rawlings M. D. or other _____
 Address Elkton - MD Date signed 1/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
County
City or town: *Edgemoor*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *13 hours*
Hospital, institution, or street address where death occurred: *Union Hospital*
How long in hospital or institution? *13 hours*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: *Ind.* County: *Cecil*
City or town: *Warwick*
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: *Wade Hampton Johns* 3. (b) Social Security Number

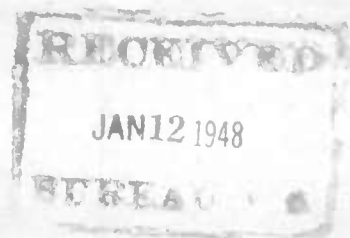
4. Sex: *M.* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *married*
6. (b) Name of husband or wife: *Bessie Johns*
7. Birth date of deceased (mo., day, yr.): *Jan, 3rd, 1877*
6. (c) If alive, give age: *?* years
8. AGE: Years: *71* Months: Days: If less than one day: hrs. min.

9. Birthplace: *Ind.* (Town, county, and state)
10. Usual occupation: *Retired merchant*
11. Industry or business: *Store Keeping, Groceries*
12. Name: *Arthur Johns*
13. Birthplace: *Del.*
14. Maiden name: *Caroline Clayton*
15. Birthplace: *Ind.*

16. Informant: *Mrs John Rodney Price*
Address: *Warwick Ind.*
17. *Burial* Date thereof: *1-10-48*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: *Forest Cemetery*
Location: *Middletown Delaware*
18. Funeral director: *F. J. Daniels*
Address: *Middletown Del.*
19. *Jan 9 19 48* *FR Frazee*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Jan. 7 1948 at 10:30 P.M.*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
and that I last saw him alive on
Immediate cause of death: *Cerebral Accident*
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Medical Examiner
Signature: *R. E. Dodson* Cecil County
M. D. or other
Address: *Warwick Ind.* Date signed: *1-7-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not collect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00410

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Cherry Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil
 City or town Cherry Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Elkton Rural
 (If rural, give LOCATION)
 2. (a) If veteran, name war Spanish-American

3. (a) FULL NAME

William W. Kelly

3. (b) Social Security Number

705-07-5145

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 26 1877
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
70 3 20 hrs. min.

9. Birthplace Cherry Hill Cecil Co Maryland
 (Town, county, and state)

10. Usual occupation Rep RR signal repairman

11. Industry or business

12. Name of FATHER James Thomas Kelly13. Birthplace md14. Maiden name of MOTHER Elyabeth A. Drummond15. Birthplace md16. Informant Miss Ethel M. KellyAddress Cherry Hill, Cecil Co Md

17. Burial Date thereof Jan 19 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill Methodist CemeteryLocation Cherry Hill md18. Funeral director Joseph R. GrantAddress North East md19. Jan 19 1948 FR Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1948 at 10³⁰ P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19³⁵ to Jan 15 1948
 and that I last saw him alive on Jan 14 1948

Immediate cause of death Coronary-renal vascular disease
 DURATION

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hubert Bates mdAddress Elkton mdDate signed 1/16/48

RECEIVED

JAN 21 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1176

00411

Reg. Dist. No. 92

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County CecilCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CecilCity or town North East
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural - #2
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary E. Kennedy

3. (b) Social Security Number

none4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife George Fredrick Kennedy

7. Birth date of

deceased (mo., day, yr.)

Jan 5 1883

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

65-21

hrs.

min.

9. Birthplace Zion, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Le Roy, England

13. Birthplace

Cecil Co., Md.

14. Maiden name

Annie Halpin

15. Birthplace

Chester Co., Pa.

16. Informant

Hospital Records

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Date thereof

Jan 29-48
(month) (day) (year)RosebankNorth East P.O. (Palmer) MdJoseph R. EvansNorth East MdJan 27 1948
JR Frazier
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26, 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 26, 1948 to Jan 26, 1948and that I last saw him alive on Jan 26, 1948

Immediate cause of death

Infarction

DURATION

Hemiparesis3 days

Due to

Myocardial Infarction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Infarction, obstructive
but cause obscure Date of op. Jan 22/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. A. C. C. C. C.

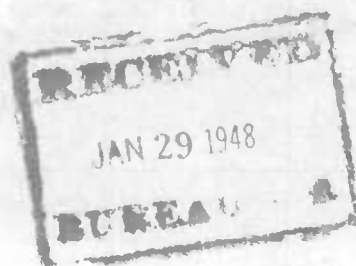
M. D. or other

Address

North East Md

Date signed

Jan 27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00412

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Becil
 City or town Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa. County Becil
 City or town Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas William Kifer

3. (b) Social Security Number

215-09-1539

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Annie Mae Kifer
 6. (c) If alive, give age 33 years
 7. Birth date of deceased (mo., day, yr.) June 9, 1897
 8. AGE: Years 50 Months 7 Days 0 If less than one day _____ hrs. _____ min.
 9. Birthplace Cumberland, Allegany, Md.
 (Town, county, and state)
 10. Usual occupation Laborer, P. R.R.

11. Industry or business

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Annie Mae Kifer
 Address Perryville, Md.
 17. Burial Date thereof Jan 12 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Principis
 Location Principis Furnace, Md.
 18. Funeral director Lee A. Patterson & Son
 Address Perryville, Md.

19. Jan 18 1948 James E. Dougherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1948, at 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death acute coronary disease
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Dodson Medical Examiner
Perryville, Md. Secil County
 M. D. or other _____
 Address _____ Date signed 1-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00413

Reg. Dist. No. 90

1. PLACE OF DEATH:

County CecilCity or town Cecil
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laura E. Laller

3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife William Laller7. Birth date of deceased (mo., day, yr.) Sept. 17 1889

6. (c) If alive, give age _____ years

8. AGE: Years 58 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Earlville Cecil Md.
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Charles H. Bailey13. Birthplace Earlville Md.14. Maiden name Emma Lee15. Birthplace Md.16. Informant Emma Laller (son)Address Earlville Md.17. Burial Date thereof Jan 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Johnston CemeteryLocation Road Earlville Md.18. Funeral director Edward A. SawyerAddress Cecil Md.19. Jan 14 1948 Mrs. Haver W. Cheyney
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CecilCity or town Cecil
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1948 at 1 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1948 to January 11 1948and that I last saw him alive on January 10 1948Immediate cause of death Coronary occlusion

DURATION

8 hrs

Due to _____

Due to _____

Other conditions gen arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thomas J. Papaschi MD

M. D. or other

Address Golva Md Date signed 1-12-48

RECEIVED

JAN 15 1948

STRA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

00414

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
County Elkton
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 days
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Elkton MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sara E. Lort

3. (b) Social Security Number

4. Sex F. 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Isaac Lort

7. Birth date of deceased (mo., day, yr.) Sept 17, 1859

8. AGE: Years 88 Months 3 Days 22. If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation H. Gr.

11. Industry or business

12. Name Tom. Lorton

13. Birthplace Maryland

14. Maiden name no information

15. Birthplace Union Hospital

16. Informant Elkton Md.

Address

17. Burial Date thereof Jan 11 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory North East Cemetery

Location North East Maryland

18. Funeral director H. W. Pissie

Address Elkton Md.

19. Jan 10 1948 J. R. Frazier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him... alive on 19...

Immediate cause of death Hypertensive Pneumonia
Pathologic fracture
Right femur
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1/25-48
Where did injury occur Elkton MD Cecil County
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fall Injured at work?

23. SIGNATURE C. E. Woodson M.D.
Address Rising Sun Md. Date signed 1-10-48
Medical Examiner Cecil County M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00415

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles Miller Lowe

3. (b) Social Security Number

216-09-3331

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Oliver R. Lowe
 6. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) Aug 10 1886
 8. AGE: Years 61 Months 5 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace North East Cecil Co. Md
(Town, county, and state)10. Usual occupation Plasterer11. Industry or business Building12. Name John Boone Lowe13. Birthplace Maryland14. Maiden name Mary Grant15. Birthplace Maryland16. Informant Joseph R. GrantAddress North East Md17. Burial Date thereof Jan 31 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MethodistLocation North East Maryland18. Funeral director Joseph R. GrantAddress North East Md19. 1/31-48 Lisa V. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Jan. 1948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to 28 Jan 1948
 and that I last saw him alive on 27 Jan. 1948

Immediate cause of death Cardiac Decompensation & auricular Fibrillation

DURATION

8 months

Due to Arteriosclerotic Heart Disease 5 years

Due to _____
 Other conditions Bronchial Asthma 10 yrs.
Pulmonary Silicosis 15 yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

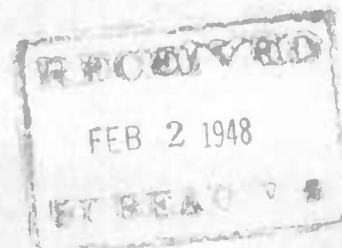
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Klaus H. Huebner M.D.

M. D. or other

Address North East, Md Date signed 29 Jan 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

00416

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH

County LeggillCity or town Elkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. 251 Mackall St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie McIntire

3. (b) Social Security Number

4. Sex

Fe.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles M. B. McIntire

7. Birth date of deceased (mo., day, yr.)

Nov 6 1892

6. (c) If alive, give age

8. AGE:

Years 55 Months 1 Days 29 If less than one day
hrs. min.

9. Birthplace

Farmington W. Va.
(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

No Inf.

12. Name

No Inf.

13. Birthplace

No Inf.

14. Maiden name

No Inf.

15. Birthplace

Charles M. B. McIntire

16. Informant

Elkton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 8, 1948
(month) (day) (year)

Cemetery or crematory

Grace Farm Memorial Park

Location

Near Wilmington, Del

18. Funeral director

H. W. Pippin

Address

Elkton, Md.

19. Jan 7 1948

(Date rec'd by registrar)

J. R. Frazier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 5 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

acute dilatation of heart

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Teeth extractionsDate of op. 1-5-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

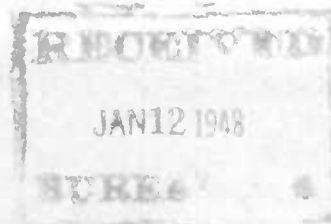
R. L. Dockson M.D.

Medical Examiner

M. D. or other
Cecil County

Address

Elkton, Md. Date signed 1-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton, R. F. D. 5
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6.5 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Elkton, R. F. D. 5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha Alberta Moore

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Curtis E. Moore

6. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) July 16, 1887

8. AGE: Years Months Days If less than one day
60 6 15 hrs. min.

9. Birthplace Pleasant Hill, Cecil Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas J. Thompson13. Birthplace Penna14. Maiden name Annie M. Curry15. Birthplace Md.16. Informant Curtis E. MooreAddress Elkton, Md. R. F. D.17. Burial Date thereon Feb 3 1888

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherry HillLocation Cherry Hill18. Funeral director J. E. TysonAddress Rising Sun, Md.19. Jan 31 19 48 J. H. Hager

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Jan 31, 1948
 and that I last saw him alive on Jan 31, 1948

Immediate cause of death Acute dilatation of heart
 DURATION 15 min.

Due to Cardio renal vascular disease 5 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Heber Bates, M.D.
Elkton Md. M. D. or other _____

Address _____ Date signed 1/31/48

RECEIVED

FEB 3 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Elkton R.D. #5, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 17 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Cecil
 City or town..... Elkton Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Cherry Hill
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Lucy O. Peterson

3.(b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... John H. Peterson
 7. Birth date of deceased (mo., day, yr.)..... October 4 1874
 8. AGE: Years..... 73 Months..... 3 Days..... 18 If less than one day..... hrs. min.

9. Birthplace..... North East Cecil Co Md
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business

FATHER 12. Name..... Isaac C. Bouchette
 13. Birthplace..... Maryland
 MOTHER 14. Maiden name..... Rebecca E. Plummer
 15. Birthplace..... Maryland

16. Informant..... George W. Peterson
 Address..... North East R.D. #1 Md

17. Burial, cremation, or removal, (Which?)..... Burial Date thereof..... Jan 24 1948
 (month) (day) (year)

Cemetery or crematory..... Bethel
 Location..... Cheapeake City Md

18. Funeral director..... Joseph R. Spant
 Address..... North East Md

19. Jan 23..... 19 48..... J.H. Frazer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 22..... 19..... 48..... at..... 3..... A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... 35..... to..... Jan 22..... 19..... 48
 and that I last saw him..... alive on..... Jan 21..... 19..... 48

Immediate cause of death.....

Cerebral embolus

DURATION

1 1/2 hrsDue to..... Chronic Endocarditis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address..... Elkton Md Date signed..... 1/22/48

RECEIVED

JAN 27 1948

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1152

00419

CERTIFICATE OF DEATH

Reg. Dist. No. 9C

1. PLACE OF DEATH:

County..... Cecil
 City or town..... Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil
 City or town..... Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Barry Snelling Poist

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... October 26, 1947
 8. AGE: Years..... 0 Months..... 2 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Harve de Grace Harford Co. Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Donald W. Poist
 13. Birthplace..... Port Deposit, Maryland
 MOTHER 14. Maiden name..... Madeline V. Snelling
 15. Birthplace..... Fredericksburg, Va.
 16. Informant..... Donald W. Poist
 Address..... Port Deposit, Md.

17. Burial..... Jan. 12 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Ashbury Cemetery

Location..... Port Deposit, Md. Rural

18. Funeral director..... R. A. Patterson & Son
 Address..... Perryville, Maryland.

19. Jan. 12 19 48 Irene E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 10, 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Jan 9 1948
 and that I last saw him alive on Jan 9 1948

Immediate cause of death..... Streptococcus Infection
thrombotic lateral sinus.
 Due to.....

Due to.....
 Other conditions..... Bi lateral Otitis Media

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Mens of injury..... Injured at work?

23. SIGNATURE..... B. H. Benson, M.D.
 M. D. or other

Address..... Port Deposit, Md. Date signed..... 1/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

James C. Rhudy Jr

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

-

7. Birth date of deceased (mo., day, yr.)

May 27 1931

8. AGE: Years Months Days If less than one day

16 7 19 hrs. min.

9. Birthplace

North East Cecil Co - Md -
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

James C. Rhudy

13. Birthplace

Graysboro, Virginia

14. Maiden name

Mary Rhudy

15. Birthplace

Tazewell Co - Virginia

16. Informant

James C. Rhudy Jr

Address

North East, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof Jan 18 1948
(month) (day) (year)

Cemetery or crematory

Methodist Cemetery

Location

North East Maryland

18. Funeral director

Joseph R. Grant

Address

North East Md

19. 1-18 1948

Lida B. Curran

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 15 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to Jan 13 1948

and that I last saw him alive on Jan 13 1948

Immediate cause of death

Acute toxic dyspnea

Due to

infection

Due to

Spastic Paralysis 16 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

North East Md

Date signed Jan 17 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

00420

82

RECEIVED

JAN 20 1948

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... ElktonCity or town... Cecil
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

George M. Short

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Aug 2 1902

8. AGE:

Years

Months

Days

If less than one day

45428

hrs.

min.

9. Birthplace

Elkton Cecil Maryland

(Town, county, and state)

10. Usual occupation

Upholster

11. Industry or business

Vidull Short

12. Name

Elkton md RD

13. Birthplace

Ann Forace

14. Maiden name

Elkton md

15. Birthplace

Melvin Short

16. Informant

Elkton 210 Bow St Elkton md

17. Burial, cremation, or removal. Which?

burialDate thereof... Feb 4 1948

(month) (day) (year)

Cemetery or crematory

Catholic Cemetery

Location

Elkton md

18. Funeral director

Elkton md

Address

Feb 3 1948

(Date rec'd by registrar)

JR Frazier

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CecilCity or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... January 30 1948 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 28 1948 to Jan. 30 1948and that I last saw him alive on Jan. 30 1948

Immediate cause of death

Disseminated Intravascular CoagulationDue to and aplanchnic Thrombosis

Due to _____

Other conditions Postnecrotic HepaticCarbuncle

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

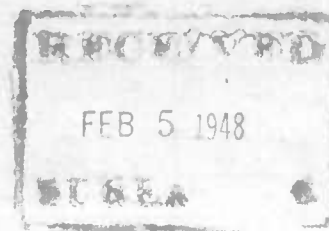
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. Foreaker, M.D.Elkton mdAddress _____ Date signed Feb 5, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00422

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil
City or town..... Port Deposit, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Life
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Cecil
City or town..... Port Deposit, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Leah Jane Smith

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed
6.(b) Name of husband or wife..... Steven Smith
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... January 26, 1850
8. AGE: Years..... 97 Months..... 11 Days..... 6 If less than one day..... hrs. min.

9. Birthplace..... Cecil Co., Md.
(Town, county, and state)
10. Usual occupation..... House Wife
11. Industry or business.....

FATHER 12. Name..... John H. Jones
13. Birthplace..... Md.
MOTHER 14. Maiden name..... Jane Taylor
15. Birthplace..... Cecil Co., Md.

16. Informant..... Irene Clark
Address..... Port Deposit, Md. Rural

17. Burial..... January 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Coakesbury
Location..... Port Deposit, Md. Rural

18. Funeral director..... Rev. A. Patterson & Son
Address..... Port Deposit, Md. Rural

19. Jan 4 19. 48 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 1 19. 48 at 8:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 21 19. 47 to Jan 1 19. 48
and that I last saw him alive on Dec 21 19. 47

Immediate cause of death..... Chronic Myocarditis DURATION..... 10 years
E. dicomposition
Due to..... Serious
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... Rev. A. Patterson & Son M. D. or other
Address..... Port Deposit, Md. Date signed..... 1-3-48

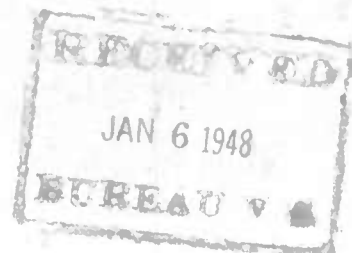
MARGIN RESERVED FOR BINDING

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9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00423

Reg. Dist. No. 91

1. PLACE OF DEATH:

County Cecil
City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs.
Hospital, institution, or street address where death occurred:
Chesapeake City, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chesapeake City
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Ella R. Warrick

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Henry Warrick
7. Birth date of deceased (mo., day, yr.) Jan. 29, 1872 8. (c) If alive, give age 75 years
8. AGE: Years 75 Months Days If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation General Housework

11. Industry or business

12. Name George Moore

13. Birthplace Maryland

14. Maiden name Josephine

15. Birthplace Maryland

16. Informant Benjamin Warrick

Address Newark, Delaware

17. Burial (Burial, cremation, or removal. Which?) Jan. 10, 1948
(month) (day) (year)

Cemetery or crematory Bohemian Manor Cem.

Location Bohemian Manor Md.

18. Funeral director Edwin R. Bell

Address 909 Poplar St.

19. (Date rec'd by registrar) Jan 29 1948 Registrar Mrs. Ralph D. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1948 at 11:40 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 32, 1948 to Jan. 6, 1948
and that I last saw her alive on Jan. 15, 1948

Immediate cause of death Cornary Thrombosis

Due to Chronic Myocarditis

Due to Coronary fibrillation

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. Davis M.D.

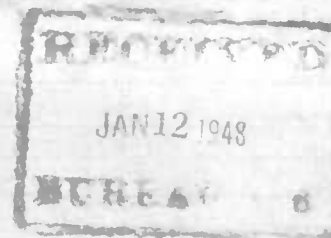
Address Chesapeake City, Md. M. D. or other

Date signed 1/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs. 4 mos. 10 days
 Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County _____
 City or town Glendale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 Carothers Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW.I ✓

3. (a) FULL NAME

WEYL, Frederick W.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) Feb. 14, 1887
 8. AGE: Years 60 Months 11 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation Miner
 11. Industry or business _____
 12. Name Unknown - deceased
 13. Birthplace Unknown
 14. Maiden name Unknown - deceased
 15. Birthplace Unknown

16. Informant Hospital Records
VA Hospital, Perry Point, Md.
 Address _____
 17. Removal Date thereof Jan. 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Charlton Cemetery
 Location Pittsburgh, Pa.
 18. Funeral director PENNINGTON & SON
Havre de Grace, Md.
 Address _____
 19. Jan 31 19 48 John E. Daugherty
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 19 48 at 2:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 19 29, to Jan. 30, 19 48
 and that I last saw him alive on January 30, 19 48

Immediate cause of death Bronchopneumonia DURATION 4-5 days

Due to Arteriosclerotic coronary disease Unknown

Due to _____
 Other conditions Hydronephrosis Unknown
Prostatic hypertrophy, benign
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE A.E. Trollinger M.D. or other _____
A.E. TROLLINGER, M.D., Chief, Professional Services
 Address VAH, Perry Point, Md. Date signed 1-31-48

RECEIVED

FEB 3 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 yrs 11 mos. 27 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State West Virginia County _____
 City or town Bellepoint
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I ✓

3. (a) FULL NAME

WIMMER, Charles A.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1 8-23-1887
 8. AGE: Years 60 Months 4 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Bellepoint, West Virginia.
 (Town, county, and state)
 10. Usual occupation Unknown
 11. Industry or business _____
 12. Name William M. Wimmer
 13. Birthplace Unknown
 14. Maiden name Deceased (Unknown)
 15. Birthplace Unknown

16. Informant Hospital Records
 Address Veterans Administration Hospital
Perry Point, Maryland
 17. Removal Date thereof 1/1/48
 (Burial, cremation, or removal. Which?) _____ month _____ day _____ year
 Cemetery or crematory Greenbrier Burial Park,
 Location 4 Miles East Hinton, West Virginia
 18. Funeral director Pennington & Son,
 Address Havre De Grace, Md.

19. Jan 1, 1948 Irene E. Dougherty
 (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1948 at 10:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 1, 1933 to January 1, 1948
 and that I last saw him alive on January 1, 1948

Immediate cause of death Pulmonary Tuberculosis, far advanced
 DURATION _____

Due to _____

Due to _____

Other conditions _____

Myocardial Degeneration
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A.E. Trolinger, M.D. M.D. or otherAddress Perry Point, Md. Date signed 1-1-48

